Robin Higginson. Physiotherapist

Robin has worked within musculoskeletal outpatients since graduating from UEL in 2006, in the NHS, while alongside setting up a successful clinic in Essex. He is now an Advanced Level Physiotherapist for Nuffield Health. Throughout this time Robin's caseload has consisted largely of persistent pain patients. In 2015 he completed his MSc in Advanced MSK Physiotherapy, and is a guest lecturer for Anglia Ruskin University.

Twitter: @RobinHigginson

I always find that research papers of Chronic pain are very good at identifying patterns, relationships, qualities or behavioural traits of certain individuals which aid our identification of persistent pain presentations, with little else in the way of telling us how to treat or improve the patient sitting with us in clinic complaining that they have pain 'all over their body'. This blog thus contains my own clinical examples of patients who have had persistent pain. Experiences of my successes, my failures, and all sprinkled with a little bit of common sense and reflective thought. If this helps further individuals in any way shape or form, then my stories haven't been wasted.

I do not classify myself as an expert in pain, far from it in fact. The collections of chapters in this book merely come from thoughts and experience of treating in a very low socio-economic area of East London, for the decade I have been practicing for. My post grad dissertation also provoked thoughts around Persistent Pain Presentations. Primarily the bulk of people I have seen have low back pain, but also neck, shoulder, and pretty much anywhere else. Although the population I treated are without doubt the clinician's greatest challenge, they can also be the most rewarding when things 'click' and go to plan.

An Introduction to Persistent Pain

If you are a medical professional reading this, you will hopefully already know a lot about Persistent or Chronic Pain. If you are not, then not to worry, as here is a very brief, not very scientific synopsis of what it is. First and foremost, this following explanation does not mean you are imagining your pain, or that it's all in your head. Quite the opposite in fact. It's a real phenomenon, which has been abundantly researched into.

Pain isn't always related to damage, injury or harm. Yes, if you hurt yourself with a kitchen knife you may get pain, and there may be damage, but this isn't always the case. Pain has conclusively been shown to occur without the presence of damage. This is the case for many presentations of LBP, where investigations and

examinations will/often not identify anything as the likely physical cause of pain. Just because there is no physical evidence however, does not mean it isn't real.

In the words of Albus Dumbledore "Of course it is happening inside your head Harry, but why on earth should that mean it is not real?" And that's just it. With regards to/pain, there is a lot that goes on inside our heads. Incoming signals from the body have to be processed by the brain in such a way that the brain decides if it feels sharp, blunt, aching, and dull or if it is worth ignoring. The brain does this by using memories of previous similar events, emotions, feelings, actions, a whole host of other ingredients in the mix, before coming up with an answer.

The easiest way of explaining this is Phantom limb pain. This is a phenomenon that amputees experience after they have lost their limb in question. They will insist that they can feel sensations coming from their hand, only their hand isn't there anymore, and hasn't been for a while. However the brain has a hard time dealing with this, as the hand was there since the person was born. It has a memory of what it looked like, a memory of what it touched, a memory of how to move it, and a memory of using it to touch things. The brain has been so used to feeling these sensations that when the limb isn't there, these signals are still being `manufactured' by the brain.

It appears however that some individuals will not develop chronic pain. These individuals after injury, when everything has fully healed will make a full recovery, never to feel pain from the area again. Some people however will. It has become apparent in research that certain behavioural traits in persistent pain seem common across individuals. In particular, individuals with depression or anxiety related behaviours such as catastrophizing, fear avoidance, and stress, are more likely to develop Persistent Pain. Why? For many reasons, all of which are complex, but has something to do with in how the brain processes information. In fact because of how complex the brain is, persistent pain doesn't only cause discomfort, it can contribute to negative effects in sleep, appetite, memory, balance…to name a few.

As a physiotherapist, this makes treatment difficult. Patients that attend physiotherapy reporting a long history of pain often say: "I don't know why my GP has referred me here I've had physio before and it didn't help". Of course traditional treatments that you may receive from a physio, which may include 'massage' and 'manipulation', may not work for persistent pain. Treatment for this type of pain NEEDS to be different, and rather than simply turning up every week for sore spots to be rubbed and things to be 'clicked', Physios face a more complex role of improving confidence levels, address fears, educating the patient, reducing anxiety of performing certain tasks, and change beliefs or bad habits that may be contributing to the individuals pain. I have written the following case examples from my practice, which add practical clarity to methods that I've implemented from reading around the subject area.

Thomas

My immediate impression of Thomas, 55, was that he was a closed character. I could tell that he didn't want to be in clinic, he had done this before, and he knew that Physio wasn't going to cure him. He has a long history of depressive illness. He didn't have a family, and was a medically retired civil servant; he was avoiding giving any detail to my questions, providing me with minimal information. His problem was quite typical in presentation. A 40-year history of back pain and neck pain that had 'always been there'. He seemed to have been prescribed Cocodamol from his GP and had taken this for 5 years, despite telling me that this medication didn't ease his pain. He had been given every investigation known to man, all of which were normal. This is common to many people like Thomas; in fact when one investigation is negative; this often causes a snow balling effect of many others being recommended, as surely one of them must show something! And that was true for Thomas. No investigation could ever show the cause of his pain because although he felt it in his body, it couldn't have been coming from it, as all the images were acceptable. In any case when his history of pain was vague and non-specific - would anyone have been so surprised that physically his back was fine?

Thomas physical examination did not demonstrate to me what was causing his pain. He could bend, lift, stretch, twist and turn. Changing the approach slightly, I then asked him whether he was a good sleeper. He explained that he has never been a good sleeper because of the pain. Of course, this may have been related to his Cocodamol use as well, but when asked how he slept before he had pain, he became uncomfortable, but slowly began talking about his history as a younger boy who was sexually and physically abused by his father, who often approached his room at night. At this point in time, several questions entered my head. Was his lack of sleep contributing to his current levels of pain? Did his current sleep difficulty reflect his previous negative experiences, or did these previous experience relate to the fact that he had a long-term history of depression? Was this the reason he struggled to be personable with people?

I was more of less sure at this point in the assessment that there was nothing physically that I could do for Thomas, he had been given exercises and treatment from Physios many times before that had made no change, and rather than encourage him, these exercises he know saw as a further waste of time. So rather that just doing the same as Physios before me, I decided not to pursue this path.

Instead, we talked. We discussed about what he thought about how and why he had arrived at this point in his journey. We also discussed a subject that no medical professional had bothered to talk to him directly about before; about the way he feels when he thinks of memories of his childhood, his father, his happiness or lack of. He explained that he held a lot of anger for his father, everyday he thought about him. We also discussed the possibilities that his current state of mind, long term depression, low mood, may be now contributing or even causing physical symptoms that people are still trying to diagnose but are unable. In this period of personal reflection, he realised that his pain had started around this period of his life. Go back 40 years or so and he would have been a teenager. Was it just that in denying his past he also avoided thinking and reflecting on events that had happened? I'm not sure, but this is common with many patients I have seen with persistent pain. They are always unsure why their pain started, mainly because they are only thinking

about physical trauma or injuries – not ‘mind’ injuries. But normally once questioned and discussed, they always reveal other major events that could have happened around that point in time their pain started.

I spend an hour with Thomas, most of which was this initially timid and apprehensive man turning into one which wanted to talk and lead the conversation, taking it where he wanted it to go and what he wanted to talk about. At the end of the session he thanked me for listening, and appeared to make some personal link to his past and the situation that he is now in. I believe he left a slightly happier man, but although probably still in pain, had been made aware that pain is a complex, multidimensional experience that may just need a degree of reflecting and acceptance, and also someone to offload to, and listen. Thomas was advised that he could self refer to a local counselling service. I never saw him again, but I hope that today that he is learning to accept his past and move on.

Ellie

I observed Ellie sitting in the waiting room, guessing from her body position and behaviour that she was the patient that corresponded to my next referral of ‘a 5 year history of neck pain’. Ellie, 36, had lived without neck pain prior to being involved in a car accident 5 years ago and had been perfectly fit and healthy, and now sat in the waiting room in an upright, rigid posture, avoiding turning her head at all costs to activity in the clinic, but instead moving her eyes and her body. Her injury history was nothing major, no broken bones or serious injuries, just a rear end shunt at a set of traffic lights. Her pain had led to a loss of sleep, recurrent time off work and eventually unemployment, strained relationships with family members, and generally low mood and motivation. Although she had no official diagnosis of depression as far as I was aware, it was quite clear that her current quality of life was pushing her towards this as inevitability. Again, she had previous physiotherapy on many occasions, and manipulation, massage over many months had not caused any change. If anything, she explained that her sessions used to cause her more pain, which would then take days to calm. She had become dependent on Tramadol, which she commented on not helping reduce her pain.

When asking her “which activities do you find difficult because of your discomfort?” Ellie replied “Everything. It’s there when I wash, when I walk, when I lay down, I can’t ever seem to escape from it.” I didn’t ask her what made her feel better, as naturally based on what she had just said her response would have been quite predictable. I spent a moment observing her perform certain tasks, walking, sitting down, turning in bed, and picking up a ball. Ellie hadn’t moved her neck at all, in any of the tasks I had asked her to perform. When I asked her why she didn’t move her neck she replied, “Because if I do, it will hurt me”. “So you think resting and not moving your neck will help you get better?” Surprisingly she replied 'Yes', at which point I attempted to make her realise that she had been doing this for 5 years and it hadn’t helped her recovery.

I wanted to start to explore why she had made the decision to avoid moving her neck, what type of an individual she was, and what her beliefs were about her neck

pain. When asked if she was an anxious personality, she explained that she used to suffer with panic attacks after the birth of her first child many years ago, but since then they had cleared up. Although all relevant investigations had been clear, she continued to worry that there was still an injury with her neck. This was a natural assumption I suppose - as the pain hadn't gone away, and also many doctors that she had seen on her journey so far had used words and terminology that made her worry and scared about moving through fear of doing herself more damage. I wondered if this was just a reflection of her old tendencies of anxiety and panic back coming back into dominance.

Ellie also explained that her life was quite stressful, children to look after, a house to maintain, along with financial issues brought along with her loss of income. She was busy, devoting no time to herself but instead to that of the needs of her family. I wasn't too sure if this was just Ellie attempting to distract herself from the situation she was in, or distracting herself from the pain.

We agreed that the first goal with Ellie was to attempt to get her in less pain when sitting. When I observed her sitting, it was clear to see why she felt pain. Her muscles must have been working over time, all the time. She was so rigid in her body position, and has sat upright for such a long time that she had forgotten how to physically relax and go floppy. I wasn't sure if this was only 'physical', as she really struggled with this task. With her history of anxiety and her current beliefs it was probably the fact that she had forgotten how to mentally switch of and relax as well. Her treatment was taken back a few steps. Rather than attempting to get her relaxed in sitting, I asked her to lay down in an effort to make it easier. We tried different techniques to get her to think about how her body felt, turning tension into areas on relaxation, performing body scan techniques etc. Once Ellie had mastered this, we focused on what sensations she was feeling from certain areas at that point in time, and attempting to get her to be aware of these sensations whilst still being able to maintain a state of physical relaxation, rather than tensing up or fidgeting. In essence, we were trying to disassociate her body's response of tensing up when she felt any sensation of pain.

Once she had mastered this, we did the same series of activities in a sitting position, and with practice Ellie was able to sit relaxed for longer periods of time, without the automatic response of sitting up straight. Ironically, when we looked at her neck movements in a relaxed sitting position, they had massively improved and became much less painful. At no point had any massage or manual therapy been performed. I feel it was at this point in time that the penny had dropped for Ellie. She saw an immediate change in her pain for the first time in years, and it was at this point we started to discuss the state of chronic stress she was in, and had been for the past 5 years. We discussed how her thoughts, worries and emotions were encouraging her body to react in a protective and tense manner, and these elements were as important to address as any other if she wanted to make a full recovery. Thankfully she trusted me, and we continued to make progress. Once she had learnt to physically and mentally calm down, her progress was swift.

We worked on getting her practicing moving her neck in a variety of different challenging tasks and environments that were relevant to her as an individual such as washing the kids at bedtime, lifting and picking them off the floor, all whilst

encouraging her to move and turn her neck more naturally. At the end of her rehabilitation, Ellie was pain free for the first time in 5 years, had come off of her Tramadol, and had returned to employment. Would the same thing have happened if I had taken a different approach to her treatment? Her previous experience says probably not, but in truth I guess we will never really know.

Graham

It seems fairly common in my experience that patient's episodes of persistent pain start after the loss of a close family member. After all, this can be a massive insult on our psychological health. It comes with a rollercoaster of different emotions all at once, and it's quite natural for people to feel overwhelmed by it all.

This was certainly the case with Graham, a 45-year-old patient of mine, who had lost his partner 2 years ago. Unlike many others, Graham was aware that his back pain had started around this time, and could give a full history of his problem. He had tried various massages, acupuncture treatments; special tools for his chair at work to help his sitting posture, but nothing to date had worked. Graham wasn't at all ignorant to the position he was in. He had already received counselling for the depressive episode that he had experienced, and like a very proactive patient had read up a lot on books that could help him adjust his mind-set on his journey out of depression. He was currently in a good 'place', more motivation, had returned to work, and wanted to return to the gym but didn't feel able as his back pain was limiting him. When I assessed his back, he had near full movements, a little bit of pain at end ranges. His main aggravating activities were sitting, and prolonged static positions of laying down in bed and standing. He had signs of his symptoms being neuropathic in origin – meaning that his pain experience showed signs of being changed or moderated by his central nervous system. Naturally I treated Graham with mobilisation, manipulation as per a traditional approach. Although commenting after that he 'felt' less pain I was unsure if I had truly influenced his discomfort because of the clinical picture I had built up. Next week Graham returned, explaining that a few hours after his treatment, his pain had massively increased, much worse than it ever had been before. This clearly told me that his 'pain system' was not able to tolerate such physical treatments or load at that point in time without an unreasonable reaction post treatment.

I wondered if this neuropathic presentation that Graham was presenting with was a physical or bodily response to the previous psychological trauma he had gone through. I played with this idea a little. I invited Graham to talk about this experience in front of me, how it affected him, good and bad points. During discussion I was able to observe his body position change. He started to place his hands on his thighs and lean forwards, and straightened his back up in sitting. When I drew his attention to if he was aware that he had done this, his reply was 'that's weird, I hadn't noticed. May pain has also increased as well.'

I then began to think if this sitting posture was a direct result of his discussion about happy events. Was this a 'fight or flight' response? Was his body preparing for action as we had just spent time discussing bad memories? I experimented further. We

started to practice visualisation exercises with Graham in a relaxed position laying down. Particularly, I wanted his to visualise a stressful memory of his choice, or a current event that he finds stressful. He chose to think about work. The sights, sounds, smells, and sensations were all things I wanted him to re-create, as this represented an environment in which he had felt pain. After concentrating on this, I wanted him to then become aware of how his body areas and back had responded to this visualisation. He was aware of this becoming more tense and feeling tight. The good news was, he was able to then control this reaction and relax his back whilst continuing this visualisation. This meant that although he was imagining being stressed, he learnt not no allow a physical manifestation of his symptoms.

His homework after this session was to go home and practice this every night. Two weeks later Graham returned, and had felt the best he had been in two years. No manual therapy or exercises were given to him on that previous treatment, so we both put it down to the homework he had been set.

We continued along this course treatment for Graham, practicing this in sitting, standing, and also with functional tasks of riding a bike. We also through relaxation techniques into his program. His progress was fantastic. After 5 sessions of treatment he was pain free for the first time in 2 years. Visually he looked happier, appeared to have more vitality, and was very thankful for the work that had been done.

On reflection of this case, I think as Graham had been through a large amount of psychological trauma, this was manifesting in a bodily reaction of tension, increased muscle activity, and 'fight or flight' response. Unfortunately, it seemed that this reaction was being triggered after such a small stimulus of stress, his normal working environment. But this is how our stress system works. The more frequent the system has been activated, the more the pathways are used, the smaller impulse it requires to stimulate a response in future. Once his attention had been drawn to this physical reaction, he appeared very good at then stopping this from happening. Hence his pain and excessive muscle activity in his back then started to reduce. He was a very satisfying patient to work with, as his overall general personality changed with quite a visible difference. This was one of many examples of how a traditional 'heart sink' who reports years of pain - can turn into something quite the opposite.

Kelly

There are some patients that I haven't been able to help, although thankfully the numbers are smaller these days. For whatever reason the patient hasn’t responded to education or discussion, or hasn’t been able to identify with the problems discussed. Kelly was such this type of patient - and what initially heightened my awareness to what could be a complex case was her 'waiting room' behaviour. As a Physio I have learnt that a really valuable time to observe a patients general attitude in in the waiting room. From the patients that stand from their chair in an apparent outward burst of expression of their pain, to others that walk towards you rather despondently with an expression that says 'I can’t be bothered'. Some patients are quite the opposite, staring at you all the way down the corridor in the hope and

desperation that you can work miracles and cure their problem, and whose bottoms have left the seat even prior to you calling their name out.

Kelly was in the waiting room, chasing her 2-year-old son around from each corner of the room. Her son was obviously in control, disobeying him mother's instructions not to climb on the chairs, and resisting any form of 'arrest' when grabbed. Quite frankly Kelly looked destroyed before we had even begun, and walked off towards the treatment area ignoring her misbehaving son until I nudged her memory and asked her if she had 'forgot' something. Her history had been confusing and muddled, and after lots of digging and questioning she had been diagnosed with postnatal depression. Her back pain had started around the same time. She had been under counselling already for her post natal depression, and explained that she had found it partially beneficial, but from my observations there were obviously still demons that she was dealing with.

Her back pain didn't assess as being particularly limiting. She has good movement, and could appear to do most tasks. Her description of pain was vague during the day, with nothing specifically being blamed as causing her pain. She reported not doing anything to start it in the first place, and didn't have back pain during or immediately post pregnancy. It was also present at night when she laid in bed.

I find this a regular report in persistent pain patients. Although not now associated as a 'Red Flag', there is probably a more logical reason to why this occurs. I wonder how many people are going to bed in the right frame of mind - one that's ready to sleep and switch off. And I also wonder how many people go to bed - and for the first time in the day they are left alone with their thoughts. They have been so good during the day at making themselves busy and distracting themselves - as is common with many anxiety type disorders - that when they are laying in bed they are still 'cognitively hyperactive' or switched on. Does this then manifest as pain? With some patients I have been unable to come up with any other logical explanation.

Kelly often became emotional in treatment sessions from discussions that did not necessarily warrant such reactions, and I become increasingly worried about her welfare and that of her child. After various communications to and from the GP, making relevant teams aware of my concern; I could re-focus on the person being sitting in front of me. Discussions around her pain were challenging. Kelly obviously hadn't made the link yet with her psychological health and the contribution this was making to her back pain. I doubt she even really fully grasped why she was in her current position.

Treatment for such complex presentations obviously needs time. Time to practice, time to talk without disturbance, time to have an effect. An it was time that Kelly struggled to make. Although not a single parent, her options for childcare for her to attended sessions was strained, as she only managed to attend once without her son. Her homework that I set for her between sessions was also rarely done, as she used to comment on not having time to practice. Maybe it was for these reasons why she found her psychology treatment only partially successful. Maybe she just didn't understand what was being done or why? Maybe she refused to let herself learn - almost like denial.

Change doesn’t happen without time. It is always important that patients are made aware of this at the outset of their treatment. Lots of patients may expect Physios to do all the work, and that none of their own practice is needed. In Kelly's case, it was her lack of time, or her apparent perspective of this, that was the source of all her problems. As clinicians, sometimes all we can do is point the patients in the right direction and encourage them to do some of the legwork. If they still don’t get the message at this point, then failure is the only option. But sometimes failure has to occur multiple times in order for change to then happen. I'm sure that with Kelly, as soon as she has failed treatment enough times and still doesn’t see any progress, will then become aware that change is needed.