Scandinavian Journal of Pain 4 (2013) 23–24

Contents lists available at SciVerse ScienceDirect

Scandinavian Journal of Pain

journal homepage: www.ScandinavianJournalPain.com

Editorial comment

What really goes on behind closed doors: The need to understand communication about pain

Chris J. Main[a], Steven J. Linton[b,*]

[a] ARUK Primary Care Sciences Centre, Keele University, ST5 5 BG, UK
[b] Center for Health and Medical Psychology, Department of Law, Psychology, and Social Work, Örebro University, Sweden

The initial visit for a pain problem in primary care is of vast importance because it sets the basis for a continued working relationship between the health-care provider (HCP) and the patient. Therefore, the spotlight has been placed on how HCPs actually communicate with their patients such as during a primary care visit. Guidelines point to a number of essential aspects, but how HCPs' handle them during a typical visit is still largely unknown. To date, we know relatively little about what goes on behind the closed door of the consultation room. The Valjakka et al. [1] study in this issue of the *Scandinavian Journal of Pain* provides an interesting and significant dimension to this research.

The HCP–patient interaction is important because there is now consensus that pain needs to be considered within a biopsychosocial framework since psychosocial factors exert powerful influence on the development of chronicity [2], and this should start at the first visit. Indeed, a host of guidelines underscore the importance of addressing psychosocial factors and providing reassurance [3]. The psychosocial component in secondary prevention programmes has progressively increased over the last two decades, but randomized-controlled-trial (RCT) outcomes have sometimes been disappointing, a consequence in part probably of a "one size fits all" approach [2,4]. However, more specifically tailored treatment requires a method of stratifying patients with some sort of screening procedure. In the recent STarTBack Trial [5], a short prognostic screening tool was developed, validated and used to match-up back pain patients into high, medium and low risk groups for chronicity and the patients were then assigned to one of three interventions developed on the basis of level of (primarily) psychological risk factors. The screening/targeting approach showed better clinical outcome with overall cost-savings. The overall "holistic" approach has been described as "psychologically informed practice" [6], essentially a "middle way" between traditional biomedical approaches and mental health interventions. In fact, when psychosocial risk factors are properly identified and then addressed with appropriate interventions, randomized trials indicate a large and significant effect [2]. Therefore, the way HCPs deal with patients in primary care evidently is crucial for the results obtained.

The biopsychosocial approach is associated with a style of patient-centred consultation. Here, communication begins with appraisal of the patients' beliefs and expectations, as a precursor to assessment and diagnosis, and leading to the provision of educational advice with appropriate reassurance [7]. Analysis of the consultation, however, requires appraisal not only of the patient's viewpoint but that of the health care practitioner (HCP), who for patients with low back pain is usually either a physician or a physiotherapist. However the attitudes and beliefs of HCPs [8] have an influence on their decision making, which in turn may affect treatment provision and clinical outcome. While it has been possible to categorize HCPs along a dimension of "psychosocial orientation" using a questionnaire, a number of issues are still unresolved making Valjakka et al. [1] a welcome contribution.

The Valjakka et al. [1] study assesses physicians' attitudes towards a psychosocial perspective of low back pain, and importantly, how they actually incorporate this into practice. Using a mix of quantitative and qualitative methods, they assess physicians' psychosocial orientation and obtain proxies of clinical behaviour. This provides a rare examination of how primary care physicians view low back pain and to what extent they follow the guideline recommendations of assessing psychosocial factors in the clinic. This is very helpful because it is a challenge to obtain data about the doctor–patient relationship in primary care settings. Admirably, this study includes 55 primary care doctors from 11 different clinics. Moreover, the study sheds light on the relationship between physicians' attitudes and their clinical behaviour highlighting its complexity. Further, it shows that while doctors are relatively aware of and positive to a psychosocial view, adherence to guidelines about incorporating these issues into actual practice is moderate to low. In fact, this study raises pertinent questions about application of a psychosocial perspective in the clinic. Not least, this study underscores the inherent problems in recommending that psychological factors be assessed, but providing no tools or routines for doing so. Valjakka et al. [1] demonstrate that the clinical application is inconsistent and probably does not meet minimal clinical standards for assessing and dealing with psychosocial issues. This is truly important and underscores the need to research further how such communication in health care is conducted.

DOI of refers to article: http://dx.doi.org/10.1016/j.sjpain.2012.08.003.
* Corresponding author.
E-mail address: steven.linton@oru.se (S.J. Linton).

1877-8860/$ – see front matter
http://dx.doi.org/10.1016/j.sjpain.2012.11.005

Table 1
An overview of some research recommendations.

Research needs	Motivation and description
Observation	Need a clear description of what happens in clinical communication. Need to isolate/categorize to understand why is successful/not successful. Related to things like emotional state of HCP and patient.
View HCP and patient as partners	To date view patient as a passive receptor. Barriers to/promoters of good communication as an active two-way process.
Routines	Tools to help clinicians assess psychosocial factors, AND communicate the results of these and assessment, treatment recommendations to the patient. How to do this best.
Implementation	What are the barriers for implementing the guideline recommended style of communication. These may well be emotional and cognitive aspects. How can we promote implementation?

HCP, health care provider.

While the study has several merits, it also has some limitations. Certainly, no study can answer all questions or control for all possible biases and the current study is not an exception. A central drawback that limits conclusions is the lack of a control group. Another significant factor is that how doctors deal with their patients is not actually observed but assessed via questionnaires and a case description. While a clever proxy, it is nevertheless a significant jump to a "live" exchange with a true patient in the clinic. The authors are aware of these problems and are therefore careful in drawing conclusions. Yet, without a manipulation or a control group it is difficult to tease out causal relationships. Thus, it is difficult to ascertain why the physicians respond to the patient case as they actually do. Further, while the study is a clear wake-up call, it provides little help in moving forward to improving the situation since there is no information about how best to change clinician's behaviour. So while this study adds a nice piece to the puzzle, we need to conduct more studies with innovative methodology.

Recommendations for future research

This article has addressed some important aspects of the consultation but there are still vital questions to answer. We have summarized some of these as a research agenda in Table 1. There is a need, for example, to experimentally isolate and manipulate aspects of communication in order to understand better the mechanisms of things like reassurance and adherence to information. Moreover, there is a need to develop and test routines for delivering the results of a psychosocial screening. Indeed, HCPs are often faced with an understudied task, i.e. to provide "good news" that there are no indications of serious pathology. But we know little about how best to accomplish this while remaining empathic. One approach in psychology is "validation" (a particular form of empathy) which seems to be of value [9]. Still, research to date has assumed that communication is the provision of information, diagnosis and treatment, delivered within a framework of empathy and reassurance with little requirement of the patient other than acceptance and adherence. However, in modern healthcare there has been an important shift in emphasis from delivery of treatment to the facilitation of self-management. This fundamentally changes the purpose and nature of the consultation in which the social context becomes of increased importance and is an arena in which beliefs and emotional responses influence the behaviour reciprocally of the two participants. New developments in implementation science have mandated a clearer focus on clinical behaviour and its determinants [10]. Careful observation is of course the first step in developing interventions, we now need to develop an understanding of the nature of these interventions and the determinants of behaviour change. In so doing we need to align our research investigations with models/mechanisms of behaviour change which can be investigated and put to empirical test.

References

[1] Valjakka AL, Salantera S, Laitila A, Julkunen J, Hagelberg NM. The association between physicians' attitudes to psychosocial aspects of low back pain and reported clinical behaviour: a complex issue. Scand J Pain 2013;4:25–30.

[2] Nicholas MK, Linton SJ, Watson PJ, Main CJ. Early identification and management of psychosocial risk factors ("Yellow Flags") in patients with low back pain: a reappraisal. Phys Ther 2011;91:737–53.

[3] Koes BW, van Tulder M, Lin CWC, Macedo LG, McAuley J, Maher C. An updated overview of clinical guidelines for the management of non-specific low back pain in primary care. Eur Spine J 2010;19:1–20.

[4] van der Windt D, Hay E, Jellema P, Main C. Psychosocial interventions for low back pain in primary care: lessons learned from recent trials. Spine 2008;33:81–9.

[5] Hill JC, Whitehurst DGT, Lewis M, Bryan S, Dunn KM, Foster NE, Konstantinou K, Main CJ, Mason E, Somerville S, Sowden S, Vohora K, Hay EM. Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomised controlled trial. Lancet 2011;378:1560–71.

[6] Main CJ, Buchbinder R, Porcheret M, Foster N. Addressing patient beliefs and expectations in the consultation. Best Pract Res Clin Rheumatol 2010;24:219–25.

[7] Main CJ, George SZ. Psychologically informed practice for management of low back pain: future directions in practice and research. Phys Ther 2011;91:820–4.

[8] Darlow B, Fullen BM, Dean S, Hurley DA, David Baxter G, Dowell A. The association between health care professional attitudes and beliefs and the attitudes and beliefs, clinical management, and outcomes of patients with low back pain: a systematic review. Eur J Pain 2012;16:3–17.

[9] Linton SJ, Boersma K, Vangonsveld KL, Fruzzetti A. Painfully reassuring: the effects of validation on emotions and adherence during a pain test. Eur J Pain 2012;16:592–9.

[10] Michie S, Johnston M, Francis J, Hardeman W, Eccles M. From theory to intervention: mapping theoretically derived behavioural determinants to behaviour change techniques. Appl Psychol 2008;57:660–80.