GOAL SETTING FOR PATIENTS EXPERIENCING MUSCULOSKELETAL PAIN: AN EVOCATIVE AUTOETHNOGRAPHY.

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Abstract

Introduction: Musculoskeletal referrals within physiotherapy are continuing to rise and pain is a common symptom which patients typically present with. Patients reporting pain following injury, or who have developed chronic pain often experience a range of physical and psychological symptoms, therefore the need to treat patients within a bio-psychosocial model is of paramount importance. Self-management is a common approach when treating patients who experience musculoskeletal pain and goal setting is an essential, and indispensable component of this. Appropriate use of goal setting has been shown to be an effective tool in pain management by improving therapeutic alliance, self-efficacy and patient adherence.

Aim: The primary aim of this paper is based on the principle researcher's (Jenny) personal and professional experiences of goal setting to explore patient needs within contemporary physiotherapy practice.

Design: This study is centred on an evocative auto-ethnography.

Results: Two distinct themes emerged from the narrated experiences. A physiotherapy mandated approach with little regard of the patient concerned was evident and that goal setting practices appeared to lack any process, which may not give patients an appropriate platform to effectively self-manage.

Conclusion: Establishing a therapeutic rapport is essential to improve the implementation of goal setting in pain management. Following a thorough process when setting goals ensures that all important aspects of the goal setting process are considered to enable patients to self-manage. These two areas are underpinned by numerous psychological theories, therefore having a better understanding of these theories may help physiotherapists to adapt and implement goal setting, as well as utilise communication more effectively when treating patients reporting pain.

Keywords: *Goal Setting, Physiotherapy, critical reflection, chronic pain, autoethnography*

Introduction: Pain management or 'positive health' has dramatically increased in recent years within a musculoskeletal (MSK) setting [(1)], subsequently causing a rise in healthcare resources [(2)]. Patients who experience pain resulting from musculoskeletal conditions present with not only physical, but also psychological issues; including anxiety, depression and fear [(3)]. These psychological issues have been related to poor patient adherence, self-efficacy and reduced exercise tolerance [(3)]. This has caused a paradigm shift from a traditional physiotherapy biomedical approach to broader management approach which includes psychological and social aspects of the well-being of patients [(4)]. According to Alonso [(5)] this bio-psychosocial model depicts a health care concept that has evolved in close association with current pain theory due to the need to address and support the psychological well-being of the patient.

Adopting a self-management approach for patients who experience MSK pain is a common, low cost intervention. The concept of self-management however is somewhat complex as it involves a number of processes including building self-efficacy, collaborative action planning and self-monitoring, all of which require an understanding of relevant psychological and social theory [(6)]. Goal setting is an essential and indispensable component of the self-management process as it engages the patient in meaningful activities regardless of pain-related complaints [(7)]. Influencing the patients 'psychological flexibility' through effective goal setting has shown to improve neurobiological levels of dopamine, and serotonin [(8)], subsequently enhancing mood state and alleviating stress. It is clear that the benefits of effective goal setting as part of self-managing patients who experience MSK pain may positively influence self-efficacy, treatment compliance, and improved self-regulation [(9, 10)]. However, goal setting used within a pain management context is in fact extremely complicated and operates on multiple levels. The relationships between goals, mood, motivation and other interpretations make it incredibly challenging [(11)]. In addition, understanding relevant psychological theories such as the patient-practitioner model, trans-theoretical model and self-determination theory may inform how goals are then set. Therefore, it would be reasonable to suggest that one goal setting approach does not fit all scenarios. In the healthcare setting, the most commonly used goal setting strategy are Specific, Measurable, Achievable, Realistic and Timely (SMART) goals [(12, 13)]. Although this

approach is underpinned by industrial/organisational research [14], it has been identified as being effective and simplistic to use. However, it is argued that SMART goals often lack a true patient centred approach therefore an understanding of alternative goal setting approaches would be of benefit to physiotherapists. [15]

I have been working as a chartered physiotherapist for fifteen years. Prior to that, I attended physiotherapy as a patient following an ankle injury. To explore my physiotherapy goal setting experiences from the perspectives of being a patient and working as a qualified physiotherapist, I chose to use autoethnography. Autoethnography is a style of writing that links the personal cultural "placing the self" [16] within a social situation. Although autoethnography has been subjected to a degree of scrutiny over the years regarding its lack of scientific evidence, there are a number of autoethnographic approaches that are widely accepted amongst researchers [17]. In particular an evocative approach tells a story which brings feelings, images or memories to mind, is a recognised approach [18]. In addition autoethnography is becoming increasingly popular within qualitative research [19], especially particular graduate and post-doctoral research because it can form the basis of a research method by acting as both a process and a product [20]. The purpose in writing my autoethnography was to present a critical self-evaluation of my personal and professional journey in relation to how my pain was managed as a patient and how I subsequently managed patients who were experiencing MSK related pain.

Writing in a reflexive manner enables the researcher to make an explicit recognition that his/her position may affect the research journey [21]. The lens through which this paper is presented is decidedly post-modern due to any ideas/thoughts highlighted from this paper has derived from the experience of the author [22]. It also captured how, my personal and professional relationship using goal setting in a pain management context facilitated a constructive line of enquiry and subsequently formed part of a PhD thesis.

The reality check - March 2004

> *My first ever patient as a qualified physiotherapist was a 73 year old gentleman who had undergone a total knee replacement. My role was to check he was managing with his knee exercises following surgery. I set the patient some goals, one of which was to independently stand on his operated leg for twenty seconds. The patient agreed and went away to work on his exercises. Two weeks later the patient returned for a re-assessment and demonstrated his ability to stand on his operated leg. It was really rewarding for me to see the patient achieve this task. I sat the patient down and said '(Mr X), I am so pleased that you have achieved your goal. Look, you can now stand on your operated leg for over twenty* seconds, how do you feel?' *The patient smiled at me, leaned over, put his hand on my knee and said, 'but the pain I have in my knee means I still can't get my paper from the shop, pet'.*

Shock

I was in a state of shock when the patient expressed his views. I felt I had completely missed the point; I had clearly set a goal that was meaningless to the patient as it had no personal value. I can't believe I didn't even ask the patient at the beginning of his physiotherapy session what his goal was. Instead, I had over-confidently created something which was only truly relevant to me. Being a reflective practitioner allowed me to channel this feeling of shock in to positive energy. Therefore with subsequent patients under my care, I tried to involve them from the outset. By balancing the relationship dynamics thorough patient engagement, I discovered more than I would have ever previously been able to access because I now provided patients the opportunity to share their thoughts and feelings. I became aware that by giving the patient joint ownership of their care they appeared to be more willing to listen and their adherence to home exercise programmes improved.

Confusion

Once the initial shock subsided, I felt very confused. I thought being qualified meant that I should have the knowledge and tools to promote a patient's potential regarding movement and function. I recall having a session on goal setting at university, taught by one of the musculoskeletal physiotherapy lecturers. The session introduced SMART goals, which referred to ensuring that all goals were set to be Specific, Measurable, Achievable, Realistic and Timely (SMART). We were taught that it was important to create goals that helped target all the problems that were identified from an assessment. The lecturer provided us with a 'text book' example of using SMART goals, which concerned a patient presenting with reduced knee flexion as a result of a total knee replacement. Then nothing else. There was no exploration of how being able to do something functional positively enhanced their daily life. I was confused because thought I was trained to set effective goals. This triggered me to reflect deeply to better understand some of my uncritical past events.

Initial impressions of physiotherapy January 1994

> *I was a keen martial artist and at the age of 13 I achieved a first Dan in Taekwondo. I distinctly remembered performing a kick but landing awkwardly and sustaining what was diagnosed as a lateral ankle sprain. My General Practitioner referred me for physiotherapy and I attended my first appointment two weeks later with my mother present because I was only 14. I hoped that the physiotherapist could make my ankle pain better straight away so that I could return to my martial arts class as soon as possible. During my first appointment, the physiotherapist turned to my mother and asked her what I had done. Following a conversation between the physiotherapist and my mother, and a very painful*

physical assessment the physiotherapist turned to my mother, and informed her about my grade two lateral ankle sprain. Towards the end of my appointment, the physiotherapist spoke to me for the first time and said, 'I am going to give you some exercises and your goal is to do your exercises twice a day'. A couple of weeks later I returned to see the same physiotherapist to have my ankle reassessed. I felt I had achieved the initial goals she set for me. I was immediately discharged from physiotherapy, but it was an additional three months of my own self-management strategies, which consisted of riding my bike before my ankle regained sufficient stability and confidence to resume my training.

Fear

My physiotherapist employed a serious approach and her style of communication was somewhat condescending. To me, as a teenager, her presence was intimidating. I felt very anxious as I had no idea what was expected of me or what the physiotherapist was going to do. I remember feeling in fear following my assessment because to me, the physiotherapist initially made my pain worse with no explanation. Instead of discussing this with my mother, I started to internalise the fear and developed kinesiophobia. Having a fear of movement made it difficult to strengthen my ankle to a level that would allow me to perform Taekwondo safely

Frustration

I felt quite indignant that the physiotherapist was not interested in my feelings, beliefs or desires. These were very meaningful issues to me, such as when I could return to my martial arts and whether it was normal to feel the level of pain I was experiencing. The level of frustration was intolerable as I had not been afforded any opportunity to ask questions. My path towards achieving my goal had been blocked due to not being involved or feeling listened to. These negative feelings initially left me feeling unmotivated, low and fluctuated depending on the level of pain I was experiencing.

Moving forward as a researcher

Writing this evocative autoethnography has enabled me to draw on the energy from these reflective processes and use these as a conduit to explore goal setting practices within the scientific literature. Presenting my past experiences in this format has highlighted a theme of; not being listened to. Not only as a patient, but also me not listening to the patients who were under my care as a physiotherapist. This clear but concerning theme regarding a lack of rapport and respect has created an opportunity to frame my experiences more deeply in the literature [19]. Building a therapeutic rapport is of paramount importance when managing patients who experience pain [23]. A balanced dialogue between the patient and physiotherapist enables the patient to not only have a voice, but to have an equal role in any clinical decisions that are made [24]. In addition, using a patient/practitioner approach is said to incorporate more micro-counselling skills such as active listening, empathy and reflection which have been empirically shown to reduce perception of pain typically for patients who experience MSK pain [25]. Furthermore, this tailored approach facilitates the patient to be led through structured self-management processes, which may empower them to choose their own behaviours as appropriate [26]. This would suggest that the greater the therapeutic alliance the more it may help patients with pain acceptance and/or managing their pain, which subsequently reducing any negative psychological experiences.

A second emergent theme was; a lack of process and understanding when setting goals. On reflection, it was apparent the training I received in goal setting as a student did not provide me with the underpinning psychological theory and practical application that was with hindsight, desperately required at the time. Considering I immediately attempted to engage future patients following my 'reality check' demonstrated the strength of my own motivation and emotions to improve the way I practice goal setting for patient who experience MSK pain [27]. To assist patients control their pain/symptoms using self-management, a structured process which involves engaging the patient, managing expectations, tailoring education and feedback positively enhances patient adherence and well-being [28]. To effectively implement this requires high level communication skills. Explaining the theory of pain to patients has been shown to reduce kinesiophobia, pain and catastrophizing according to Tichonova, Rimdeikien [29]. In addition, reducing any exaggerated negative reactions to pain through appropriate education may positively enable a successful return to function [29]. Indeed Moseley [30] states that targeting a patients cognitive and behavioral aspect of pain through education aims to affect change through re-conceptualisation of their symptoms. In addition, educating the patient may reduce the number of patient concerns and promote more patient satisfaction. This highlights that due to the numerous aspects associated with self-management and goal setting, using a process will ensure that all important aspects are being considered.

The literature reports that physiotherapists perceive themselves as being competent at setting goals [31], however there is evidence that physiotherapists would welcome further training in using psychological tools with goal setting being identified as one of those tools [32]. Heaney, Green [33] conducted a mixed methods survey investigating the psychology content of UK physiotherapy education and patient satisfaction. Results indicated that patients felt that the goals being set were not patient or psychologically focused. In addition, they felt that goals were largely objective-related as opposed to function. In addition, using this holistic process of enquiry provided me with more social and cultural insights in to the physiotherapy as a profession compared to other scientific

methods of enquiry [34]. Re-visiting a personal experience from a reflexive and reflective standpoint may act as a new site to which new possibilities can be explored [20]. For example, introducing a more MSK related goal setting framework as opposed to SMART and exploring the most effective method to implement goals to optimise pain management. Reflecting upon the emotions that I experienced both as a patient and a qualified physiotherapist, has created a research interest to further explore practices within physiotherapy.

Conclusion

Re-evaluating my past has enabled me to reflect through a critical lens upon situations that were never questioned. Despite the fact goal setting practices within the scientific literature have continued to evolve over the past decades [35], it would appear that goal setting practices in physiotherapy may not have evolved enough. In addition, establishing a therapeutic rapport when working with patients who experience pain is not only essential, but it requires a comprehensive understanding of this field. It is of paramount importance that a goal setting process is implemented to ensure that vital aspects of this process are not missed. This autoethnography has allowed me to connect my personal relationship with the profession and retrieve insightful aspects of goal setting practices and communication skills that would benefit from being explored using scientific methods of enquiry. As a starting point, conducting a large literature review may highlight a number of questions that could then be then further examined through a survey or interviews based study. The benefits of having initially used a pseudo-scientific approach is that this approach allows depths and interpretations of feelings and emotions that science would not be able to reach. One example of this was exploring my reflections following my goal setting autoethnography and highlighting potential research questions. However, the concept of authenticity is often challenged when writing autoethnographies [36]. In addition, personal impressions and thoughts are not seen as important from a scientific perspective [37]. Just because autoethnography does not adhere to traditional notions of objectivity, writing in an autoethnographical manner allows my experiences to be described and comprehended in different ways.

It is hoped by unpacking and examining what may seem basic skills (goal setting and communication) this paper encourages physiotherapists to give these aspects great consideration. Further self-reflection and awareness of the psychological theories such as the patient-practitioner model, trans-theoretical model and self-determination theory may provide them with more understanding and clinical reasoning. Rather than goal setting for patients as in this paper's title, physiotherapists should perhaps consider applying goal setting that involves and engages patients.

References:

1. Buchbinder R, van Tulder M, Öberg B, Costa LM, Woolf A, Schoene M, et al. Low back pain: a call for action. The Lancet. 2018.

2. Foster NE, Anema JR, Cherkin D, Chou R, Cohen SP, Gross DP, et al. Prevention and treatment of low back pain: evidence, challenges, and promising directions. The Lancet. 2018.

3. Booth J, Moseley GL, Schiltenwolf M, Cashin A, Davies M, Hübscher M. Exercise for chronic musculoskeletal pain: a biopsychosocial approach. Musculoskeletal care. 2017;15(4):413-21.

4. Woby S, R., Roach N, C., Urmston M, Watson P, J. Outcome following a physiotherapist-led intervention for chronic low back pain: the important role of cognitive processes. Physiotherapy 2008;94:115-24.

5. Alonso Y. The biopsychosocial model in medical research: the evolution of the health concept over the last two decades. Patient education and counseling. 2004;53(2):239-44.

6. Lorig K. Self-management education: more than a nice extra. Medical care. 2003;41(6):699-701.

7. McBeth J, Jones K. Epidemiology of chronic musculoskeletal pain. Best practice & research Clinical rheumatology. 2007;21(3):403-25.

8. Farouk A. Impact of psychological rehabilitation program on self confidence level and competition anxiety for soccer players of anterior cruciate ligament injury. World Journal of Sport Sciences. 2010;3:138-43.

9. Evans L, Hardy L. Injury Rehabilitation: A Goal-Setting Intervention Study. Research Quarterly for Exercise and Sport. 2002;73(3):310-9.

10. Levack, Taylor K, Siegert RJ, Dean SG, McPherson KM, Weatherall M. Is goal planning in rehabilitation effective? A systematic review. Clinical rehabilitation. 2006;20(9):739-55.

11. Levack, Dean, McPherson, Siegert. Evidence-based goalsetting: Cultivating the science of rehabilitation. Rehabilitation goal setting: Theory, practice and evidence. 2014:21-44.

12. Playford ED, Dawson L, Limbert V, Smith M, Ward CD, Wells R. Goal-setting in rehabilitation: report of a workshop to explore professionals' perceptions of goal-setting. Clinical rehabilitation. 2000;14(5):491-6.

13. Grant M, Economou D, Ferrell B, Uman G. Facilitating survivorship program development for health care

providers and administrators. Journal of Cancer Survivorship. 2015;9(2):180-7.

14. Locke E, Latham G. Goal setting: A motivational technique that works! . Englewood Cliff: Prentice Hall; 1984.

15. Heaney C. The impact of sport psychology education on the practice of physiotherapists. International Sports Science and Sports Medicine Conference; Newcastle Upon Tyne2013.

16. Reed-Danny D. Auto/Ethnography:Rewriting the Self and the Social. Oxford: Berg; 1997.

17. Holt NL. Representation, legitimation, and autoethnography: An autoethnographic writing story. International journal of qualitative methods. 2003;2(1):18-28.

18. Pensoneau-Conway SL, Adams TE, Bolen DM. Doing Autoethnography. Doing Autoethnography: Springer; 2017. p. 1-5.

19. Anderson L. Analytic autoethnography. Journal of contemporary ethnography. 2006;35(4):373-95.

20. Toner J, Nelson L, Potrac P, Gilbourne D, Marshall P. From 'blame'to 'shame'in a coach–athlete relationship in golf: A tale of shared critical reflection and the re-storying of narrative experience. Sports coaching review. 2012;1(1):67-78.

21. Berger R. Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. Qualitative Research. 2015;15(2):219-34.

22. Hsu WF. DIGITAL ETHNOGRAPHY. The Routledge Companion to Digital Ethnography. 2017:40.

23. Potter M, Gordon S, Hamer P. Identifying physiotherapist and patient expectations in private practice physiotherapy. Physiotherapy Canada. 2003;55(4).

24. Barr J, Threlkeld AJ. Patient–practitioner collaboration in clinical decision-making. Physiotherapy Research International. 2000;5(4):254-60.

25. Schwab Reese LM, Pittsinger R, Yang J. Effectiveness of psychological intervention following sport injury. Journal of Sport and Health Science. 2012;1(2):71-9.

26. Du S, Yuan C, Xiao X, Chu J, Qiu Y, Qian H. Self-management programs for chronic musculoskeletal pain conditions: A systematic review and meta-analysis. Patient education and counseling. 2011;85(3):e299-e310.

27. Laslett B, Church K, Gullestad M, Kaplan T, Kreiger S, O'Farrell B, et al. Personal narratives as sociology. JSTOR; 1999.

28. Brewer BW, Van Raalte JL, Cornelius AE, Petitpas AJ, Sklar JH, Pohlman MH, et al. Psychological factors, rehabilitation adherence, and rehabilitation outcome after anterior cruciate ligament reconstruction. Rehabilitation Psychology. 2000;45(1):20-37.

29. Tichonova A, Rimdeikiené I, Petruševičiené D, Lendraitiené E. The relationship between pain catastrophizing, kinesiophobia and subjective knee function during rehabilitation following anterior cruciate ligament reconstruction and meniscectomy: A pilot study. Medicina. 2016;52(4):229-37.

30. Moseley L. Combined physiotherapy and education is efficacious for chronic low back pain. Australian Journal of Physiotherapy. 2002;48(4):297-302.

31. Lafferty M, Kenyon, R, Wright, C. Club-based and non-club based physiotherapist's views on their psychological content of thier practice when treating sports injuries. Research in Sports Medicine. 2008;16(4):295-306.

32. Alexanders J, Perry J, Douglas C. Physiotherapists perceptions of goal setting practices used for patients following anterior cruciate ligament surgery: University of Hull; 2016.

33. Heaney C, Green A, Rostron C, Walker N. A qualitative and quantitative investigation of the psychology content of UK physiotherapy education. Journal of Physical Therapy Education. 2012;26(3):1-26.

34. Atkinson P, Delamont S. Rescuing narrative from qualitative research. Narrative inquiry. 2006;16(1):164-72.

35. Locke EA, Latham GP. New developments in goal setting and task performance: Routledge; 2013.

36. Lovell S. Seductive whisperings: Memory, desire, and agency in auto/biography. thirdspace. 2005;4(2):32-44.

37. Ottenberg S. Thirty years of fieldnotes: changing relationships to the text. Fieldnotes: The makings of anthropology. 1990:139-60.