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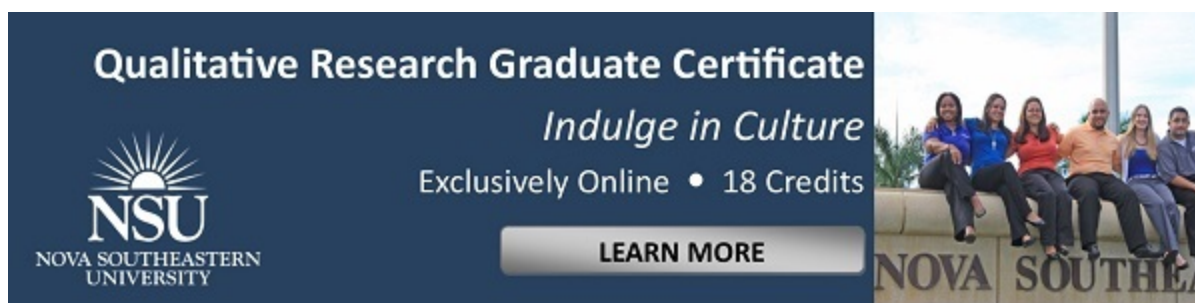
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## The Magic Wand: A Case Study of Chronic Neck Pain

### Abstract

Medications used to manage chronic pain have documented side effects including drug dependency, drug interaction, and adverse systemic reactions. This case study used Interpretative Phenomenological Analysis to understand how one individual experienced chronic neck pain including pharmaceutical and non-pharmaceutical interventions. Convenience sampling identified Ms. P, an individual with a 10-year history of chronic pain. The research questions were: “How does one individual with chronic neck pain describe their experience living with neck pain?” and “How does one individual with chronic neck pain manage their pain?” Three super-ordinate themes emerged: pain pervades everything, finding relief, and recovery. Findings suggest that living with chronic pain is framed by both the experience of severe pain and the search for a cure. Fear, panic, and despair accompany ongoing pain. Initially, the participant’s physician prescribed medications including narcotics, which are described as a slippery slope. In desperation, the participant sought alternative treatments.

### Keywords

Pain, Phenomenology, Interpretative Phenomenology Analysis Chronic Pain, Neck Pain, Acupuncture, Laser Therapy, Massage, Ultrasound, Complementary and Alternative Medicine

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# The Magic Wand: A Case Study of Chronic Neck Pain

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## Introduction

Chronic pain costs the US \$635 billion annually which is more than the yearly costs for cancer, heart disease and diabetes (Gaskin & Richard, 2012). The incidence of self-reported neck pain in the general population is 213 per 1,000 persons (Hogg-Johnson et al., 2008). Pain is managed largely by pharmaceutical intervention. Pain medications, however, may have side effects including drug dependency, drug interaction, and adverse systemic reactions. While pharmaceutical intervention is considered "usual care" (Hurwitz et al., 2009; van der Velde et al., 2009), there is increasing concern about adverse effects (gastrointestinal, cardiovascular, mortality) of chronic analgesic use and polypharmacy (Adams et al., 2011; Caughey, Roughead, Pratt, Killer, & Gilbert, 2011; Reid et al., 2011; Roth & Anderson, 2011), and prescription drug abuse (Becker et al., 2009).

Sales of opioids, one of the most commonly prescribed pain relievers, increased four-fold between 1999 and 2010 (CDC, 2011). The substance abuse treatment admission rate in 2009 was almost six times the rate in 1999 (CDC, 2011). According to systematic review results (Morasco et al., 2011), 28%-42% of primary care and 15%-50% of outpatient pain clinic patients have history of substance use disorders. More deaths are attributed to prescribed painkillers than to cocaine and heroin combined or to motor vehicle accidents. In a study of persons using opioid analgesic prescriptions for a pain (Dunn et al., 2010), the annual overdose rate was 256 per 100,000 person-years in patients who recently received medically prescribed opioids compared with 36 per 100,000 person-years in the subsample who did not. Painkiller deaths have increased by 300% since 1999 (CDC, 2011). In spite of the widespread use of opioids, opioid medications may result in as much as a 30% reduction in pain for only half of the patients who use them (Bloodworth, 2006).

In addition to pharmaceutical interventions, surgeries (fusion, disc replacement), regional anesthetic interventions such as steroid injections, rehabilitative/physical therapy and complementary and alternative medicine treatment modalities are used to relieve and/or

manage pain (IOM, 2011). Invasive and expensive surgeries are considered a last resort. No strong evidence to support anesthetic injection therapy has been found except for some specific types of patients (Luijsterburg et al., 2007; Staal, de Bie, de Vet, Hildebrandt, & Nelemans, 2008). Rehabilitation/physical therapy has been found to reduce pain intensity and use of pain medications (Hoffman, Papas, Chatkoff, & Kerns, 2007). Nearly half of people with pain seek help from complementary and alternative medicine practitioners (Wells, Phillips, Schachter, & McCarthy, 2010).

The focus of this case study is to use Interpretative Phenomenology Analysis (IPA; Smith, Flowers, & Larkin, 2009) to understand the journey from pharmaceutical to alternative care for one patient with chronic neck pain. A study (Scherer, Schaefer, Blozik, Chenot, & Himmel, 2010) of how patients experience neck pain, their impression of different therapies, and the expectations they bring to physician- offices, and. found that participants preferred self-care (measures (analgesics while voicing concern about toxic, addictive, gastric side effects), exercising, relaxation, heat packs, warm showers, and electrical stimulation) and sought physician care only when self-care measures failed. Physician visits were seen as an extension of self-help, i.e., when self-help was no longer effective, patients sought prescriptions for massage, physiotherapy, and/or local anesthetic injections. Most subjects reported experiences with therapies such as physiotherapy, massage, injections, and acupuncture but complained about their inefficiency. The terms massage and physiotherapy were used interchangeably by participants who reported that massage was effective for temporary relief. Injections also only had a short-term effect. A limitation of this study was that the range of alternative interventions was limited and was not explored in depth.

In-depth probing techniques were used during focus groups to compare conventional primary care with conventional primary care plus complementary therapies (Andersson, Sundberg, Johansson, & Falkenberg, 2012). Participants characterized conventional primary care as specialized (laboratory testing, expert referrals), and reductionist (focusing on the disease). Many patients sought conventional care to obtain paid sick leave. Participants characterized integrative care as holistic, open, with dialogues that probed multiple aspects of patients' lives and activities of daily living. While participants acknowledged conventional care provided diagnostic support, they rarely acknowledged that conventional care providers provided medical explanations for nonspecific pain. Participants who received complementary therapies along with conventional primary care reported decreased use of analgesics and feeling more positive, self-aware, and empowered to take responsibility for their health. Experiences from the holistic approach where they discovered that their back pain was, linked to a knee injury and when both were treated, the pain decreased. The conventional care participants reported difficulty getting personal contact with the primary care unit and long waiting times to get an appointment. The integrative care participants perceived the two approaches as competing with each other with little communication between.

The literature describes when and perhaps why patients with chronic pain use complimentary/alternative therapies. The gap in the literature then, is not access to complimentary/alternative therapies but rather how individuals select which of the complimentary/alternative therapies they would like to use. The purpose of this study was to test a semi-structured interview schedule with one individual with chronic neck pain in preparation for a larger study that will explore the experiences and perceptions of individuals living with chronic neck pain, including how they make choices about complimentary/alternative therapies.

Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) was used because the goal of this research was to understand in detail what the experience of living with chronic neck pain was like for this subject and what sense this person made of what was happening to them. IPA is grounded in Health Psychology and is based on the phenomenology,

hermeneutics, and ideography philosophies of knowledge. Phenomenology, or the “complex understanding of “experience” invokes a lived process. The IPA method is influenced by the hermeneutic circle that describes the process of looking at the whole to understand the parts, and vice versa, and the idiographic or particular approach (versus the generalized approach) where a particular phenomenon is understood from particular people in a particular context (Smith et al., 2009). IPA methodology has been used in studies of low back pain and pain from multiple sources. Using IPA to analyze patient drawings participants with multiple sources of pain (Kirkham, Smith, & Havsteen-Franklin, 2015), pain was described as sinister, violent, and punitive. In a study of nine women with pain (Osborn & Smith, 1998), four themes emerged: “Searching for an Explanation” to understand their pain, “Comparing this Self with Other Selves” and feeling lost that they could not do things they should be doing at their age, disturbing their social order, “Not Being Believed” by others that the pain was real because pain can’t be seen, and “Withdrawing from Others” wanting to conceal their pain and feeling that they are a burden on others. A later study of six patients with chronic back pain (Smith & Osborn, 2007) further explored the debilitating impact of chronic pain on sense of self. Our study describes one person’s journey to conquer pain and regain herself.

### **Methodology**

This study was approved by the Institutional Review Board at Nova Southeastern University. The study used a single case design (Smith et al., 2009). The research questions that guided this pilot study were (1) How does one individual with chronic neck pain describe their experience living with neck pain? (2) How does one individual with chronic neck pain manage their pain?

### **Epoché**

The author is a rehabilitation clinician and researcher. While the author engages in pain-related research, the author is not a pain expert and has not personally experienced chronic pain; rather, she focuses her research on advocacy and equity to health care resources. The author is interested in promoting the intervention that has the greatest benefit for both the patients and society. One of the author’s research topics is the effectiveness of laser therapy; therefore, she may have a bias towards laser therapy. The author challenged her preconceptions by focusing on the information shared by the study participant, relying on the established open-ended interview questions, using direct quotes by the interview participant to evidence meaning, and by sharing thematic findings with the participant for validation. Member checking, requesting the participant to review the study results and make changes where necessary so the findings accurately reflected the participant’s lived experience, was performed as a strategy for additional validation.

### **Subject**

Convenience sampling was used. The author and a complementary and alternative chiropractic practitioner colleague were working on a grant proposal that would use mixed methods to investigate the use of laser therapy intervention for chronic pain. The study described in this article piloted the semi-structured interview schedule to be included as an appendix in the grant proposal. The first patient that the chiropractor colleague asked indicated she was interested in learning more about the study. The chiropractor colleague contacted this particular patient first because of the advocacy work she has done for others with chronic pain. The chiropractic colleague gave the patient the author’s contact information. The patient

subject contacted the author by email. A phone appointment was made during which the interview was explained. After the course was completed, it was suggested that the case study of this depth would be a unique contribution to the literature. Nova Southeastern University Institutional Review Board approved the use of retrospective clinical data for publication as a research study.

### Data Collection and Preparation

The author conducted one single semi-structured interview over the phone, using questions developed by the author based on her clinical expertise as an occupational therapist. The author took field notes during the audio-recorded interview. The interview was transcribed word-by-word by the author.

### Data Analysis

The transcribed interview was analyzed using Microsoft (MS) Word following the IPA procedure described by Smith et al. (2009). First, the text was read several times. Second, with the transcribed interview in the middle column, going line-by-line, the left column was used to note interesting or significant statements (Charmaz, 2014; Smith et al., 2009). The third step returns to the beginning of the transcript to, in the right column, note emerging themes. See Table 1.

Table 1 Initial coding process		
Significant Statements	Transcribed Interview	Emerging Themes
Pain gets in the way Pain pervades everything  Pain is distracting Being distracted is frustrating  I can't do what I need to do	P: Um, first of all umm the pain is often ah I find it that it gets in the way of my being able to ah be as productive in terms um sometimes the pain is not um it's so um pervades everything that I do even my even my ability to sit and think um because its distracting um . . . now not always but certainly when its bad it really is and so its um I find that's frustrating and annoying because um my mind is often taken to the pain and away from the things that I need to get done in the course of the day including my my business I'm a business owner . . .	Pain is often Pain get in the way of being productive Pain pervades everything I do even sitting and thinking Pain is distracting, not always but when it is bad it is really distracting Distraction is frustrating. My mind is taken to pain and away from think I need to get done <i>um</i>

Fourth, a MS Word document was created for each emergent theme that contained the associated transcript extracts. Finally, the author searched for patterns and connections between the themes to identify super-ordinate themes. See Table 2.

Table 2 Example of developing superordinate themes		
Themes	Age.Line	Key Words
<i>Pain pervades everything</i>	1.8	in the way
Pain gets in the way, can't do what I need	1.11	distracting, frustrating,

to do		annoying
Pain is distracting, being distracted in frustrating, pain and distraction are annoying	1.24	scary
Debilitating emotionally, pain is scary	1.16	panic
I panic, I worry if it will go away	1.19	fear
We have the fear factor	1.17	getting better
Wonder will we get better? What do we need to do to get better?	1.8	in the way

## Results

Three super-ordinate themes emerged from the text: pain pervades everything, finding relief, and recovery.

### Pain Pervades Everything

When asked to describe what she experienced in her daily life as an individual with chronic neck pain, Ms. P reported that the pain kept her from being productive. Ms. P described the pain as distracting, frustrating, and annoying because she could not get done what she needed to do:

*I find it that it gets in the way of my being able to ah be as productive in terms um sometimes the pain is not um it's so um pervades everything that I do even my even my ability to sit and think um because its distracting . . . my mind is often taken to the pain and away from the things that I need to get done in the course of the day including my my business I'm a business owner small business owner umm and and also my other you know my daily routines as a mom um the simplest things from cooking a meal and um um picking up around the house or doing laundry . . .*

After a few days of pain, the annoyance gave way to being scared and even panic, wondering if the pain was ever going to go away.

*after a couple of days and it's not going away I start to worry about well when will it go away? will it ever go away? um will I have to live like this always*

Ms. P describes this panic as “the fear factor.” Being preoccupied with pain and worrying about whether the pain is ever going to go away becomes emotionally debilitating.

*. . . um really debilitating too on an emotional level um because then you find yourself sort of preoccupied with the notion that um you know are you going to get better?*

## Finding Relief

Ms. P's chronic neck pain began when she was in her twenties. Initially she went to her family medical doctor who prescribed muscle relaxants that left her depressed and drowsy:

*I had a new born baby and ah I do do remember thinking and I lived in a a old colonial house and I remember thinking as I was walking down the stairs ah um with the baby in my arms that you know this is not safe this is not good for me to be walking with a baby in my arms feeling dizzy, disorientated, groggy . . .*

Besides the pharmaceutical side effects, Ms. P found going to her medical doctor frustrating. They could not see what was causing the pain and perhaps did not know what to do other than prescribing analgesics.

*you go to the doctor and you say help me you know I'm in pain and they go through all the routine examinations. At that point there wasn't any other evidence ah ah um ah you know as far as radiological exams or any other exams that were available to me at the time showed that there might be any um sort of more anatomical reason there was no cervical da . . you know disc damage anything like that no no ruptures . . .*

Relying on medication for pain relief, Ms. P developed "sort of grinding feeling kind of icky" that was diagnosed as two stomach ulcers:

*. . . years of popping aspirin and Advil and anything else I could do to alleviate pain in my neck was actually creating a whole 'nother and very serious potentially serious problem in my gut . . .*

It was not clear at what point Ms. P began taking narcotics, which she described as a "slippery slope", but Ms. P did come to realize that she did "not want to live popping pills". The fear factor continued.

*. . . if the treatment's working it's a wonderful thing if the treatment's not working um it further compounds sort of the the the feeling of despair or fear that you are not going to get any relief and ah when the pain is bad sometimes you just think boy it's it's just not fun living like this.*

In desperation, and upon recommendation of psychologist she was seeing professionally who was also a friend, the subject turned to alternative treatment:

*. . .you're looking for the magic you know the magic wand out there and and uh you're willing to try almost anything.*

Ms. P began alternative interventions with massage therapy with a clinician deemed credible because he worked for a ballet troupe.

*if he can work on those people and make them feel better, he'll help me feel better.*



During this time, Ms. P was introduced to chiropractic, ultrasound, acupuncture, and laser therapy:

*massage, ultrasound, uh adjustments which definitely helped keep me um you know in a place of um you know relative comfort . . . I have done acupuncture before and I certainly have had some success with that as well so um but anyway the laser . . . was um just wonderful.*

The author then probed the subject on the quality of each of the alternative interventions in an effort to understand why the subject continued with massage, chiropractic adjustments, ultrasound, acupuncture, and laser therapy, hoping to elicit the uniqueness of each. The subject spontaneously compared the interventions by time (e.g., how long the sessions lasted and how long interventions took for pain relief to be felt) and the relative comfort of each intervention.

*. . . for some of my treatments so you know again you're in and you're uh out much quicker so that's a bonus.*

Massage was one half to a full hour, ultrasound 15-20 minutes, and laser four minutes. The benefits of ultrasound are felt hours later or the next day whereas the benefit of the laser is instantaneous:

*. . . the ultrasound I sort of noticed that the effects were maybe over a period of maybe hours and even into the day later whereas laser is you know I can walk in there and and be miserable and I can walk out and and be feeling much relieved you know. As I said pain on an 8 and a half down to like to a three by the time I walk out the door and sometimes I I get even you know down to like no pain . . .*

Ms. P also compared the comfort of massage, ultrasound, and the laser on the level of pain and tactile sensation, e.g., the feeling and effect of the ultrasound gel.

*Massage is is certainly very effective at getting the muscle spasm to you know to calm down . . . when someone is massaging something that's that tight that's that sore they are you know they're using knuckles and elbows and they're you know they're really working you out to get try to get that muscle to release so that's um you know the end result is wonderful but getting there is excruciating.*

Ultrasound on the other hand was "gooey":

*I also like the fact that laser isn't gooey because with ultrasound of course they gotta to slap all that gel all over you . . . [laugh] so you know you of course with neck and shoulders then you know there goes the hair do right [laugh]. . . I'm not vain but you know it's kind of bad when you have to go to work and your hair looks like some punk rocker cause it's sticking out in 50 different angles at the back.*

The subject then compares the laser intervention on both the time and comfort factors.

*I also like the fact that laser isn't gooey . . . so again contrastingly the laser tends [laugh] nobody's is poking on you and pushing on you until you're*

*screaming uncle you know and you're getting the same end result and again you're getting it so much faster . . .*

## Recovery

It wasn't until Ms. P found laser therapy that she entered the recovery phase. The subject characterizes recovery as:

*. . . I'm not undone by it mentally or emotionally . . . I don't have that sort of feeling of of sadness and fear that I used to have years ago.*

While admitting that pain is a part of who she is, knowing where the relief has freed her from panic and the fear factor.

*. . . every once in a while I have a flare up . . . but the nice thing now is that I don't panic anymore [laugh] because I know where relief is and it's not in a bottle . . . I know it's going to come quickly, I know I don't have to take drugs, I don't have to upset my stomach, uh I know that it's painless you know . . .*

The subject realizes that while pain is a part of who she is, the difference is that now she has learned how to manage it.

*. . . what we have to do is manage it rather than . . . you know I don't know that there's a cure for this particular thing but management is key . . .*

Learning how to manage her pain gave her life back:

*. . . I have actually reached the point where I actually can go as I said for months with no pain and no problem so um that is something that I never did before. I was always seeing the doctor on a regular basis at least one a week sometimes twice and three times a week and that's a lot of time to be you know out of you life no matter who you are to be running back and forth to the doctor.*

In spite of all that she has endured, Ms. P describes herself as fortunate and lucky: fortunate to discover alternate therapies and lucky to have learned about them via word of mouth.

*I think that the greatest referral you can get is from a person who's experienced uh either a similar situation or or is working with people um in that ah in that specific area and has heard from others the success stories then and then tells you . . .*

## Discussion

While piloting an interview schedule for a larger-scale research proposal, the author had the opportunity to explore the experience of pain for a single patient. The journey from onset to recovery for this patient with chronic neck pain began with traditional pharmaceutical intervention, aspirin that progressed to narcotics and ulcers. In desperation, she, like others before her (Andersson et al., 2012; Scherer et al., 2010), turned to alternative therapies. Years later, it was laser therapy that freed her from panic because laser therapy provided the fastest relief, had the shortest length of intervention (minutes) and had the longest lasting effect.

Our findings support a qualitative study of chronic neck pain in an elderly population (Holmberg, Farahani, & Witt, 2016) embedded in a randomized control trial (RCT) that compared the experience and value of qigong (postures to improve blood flow) and exercise therapies. Participants described their pain as the background for every day experiences which frequently led to negative social consequences (e.g., unable to complete work load). In addition, participants spoke of their pain in terms of fear and feeling helpless. Patients were interested in the study because they wanted something they could do themselves, without having to take a pill. The two exercise methods viewed somewhat differently by participants in the Qigong exercise group reported decreased acute pain, increased relaxation, improved sleep, improved social relationships, and an improved ability to sense a pain attack and self-manage with qigong exercises. Participants did not, however, continue the qigong exercises at the end of the study. Participants in the traditional exercise group reported muscle relaxation, increased body posture awareness and the ability to manage pain with the exercises. Participants in the traditional exercise group reported integrating the exercises into their daily routine and continuing their exercises beyond the study period.

### Limitations

The author acknowledges the limitations of this study. First, the subject of this case study was recruited by her health care provider who was writing a grant proposal with the author, both of whom have an interest in laser therapy. A second limitation is that a follow-up interview was not performed.

### Conclusion

IPA has been used to explore the assault of pain on the identity of self. Qualitative studies embedded in RCTs have compared standard care to alternative interventions to standard care. This is the first known study using IPA to understand one subject's journey from "popping pills" to recovery with a detailed comparison of acupuncture, ultrasound, massage, chiropractic, and laser alternative therapies.

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